MEDICAL EVALUATORS
OF TEXAS ASO, L.L.C.
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800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: January 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical Epidural Steroid Injection at bilateral C7 level under fluroscopy with possible monitored anesthesia (64479, 77003, 01992).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a physician who holds a board certification in Physical Medicine and Rehabilitation and is currently licensed and practicing in the state of Texas.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The patient is a female with a history of work-related injury to her neck sustained on 12/16/1997. Her surgical history includes cervical fusion x2 at C4-C7. Her past surgical history includes lumbar fusion at L5-S1in 2011 and spinal cord stimulator placement in 2013 as well as right carpal tunnel release in 2008. She has a history of cerebrovascular accident in 2007, with good recovery and a little left facial droop residual. She is currently in the final 25% of her functional restorational program. It was reported that the patient is using a cane which she is slow to discontinue because of some increasing leg pain, that was documented to be relieved with ESIs.

Injection consultation dated 09/24/2014 documented that the patient has prior injections, the last being in January 2013 and resulted in 80% pain relief. Upon examination of the cervical spine, alignment was intact, and cervical lordosis was well maintained. Cervical ROM was reported to be severely restricted in flexion, extension, rotation, and

sidebending with both flexion and extension reproducing neck pain radiating to the bilateral arms to the elbows. Neurological examination showed DTRs to be 2/4 and symmetric in the biceps, triceps, and brachioradialis tendon. Motor power was 5/5 and symmetric between myotomes C5 and T1, though there was give-way weakness due to pain. Sensation was reported to be well- preserved in the upper extremities. And the physician recommendations were that the patient is having some persistent exacerbation of radicular symptomatology in the bilateral upper extremities and would be a good candidate for cervical epidural steroid injection.

On 10/14/2014, she was examined who reported the neurologic exam to show good coordination with no objective deficits of strength, sensations, or reflexes. Extremity joints showed good stability and ROM, without deformity, malalignment, effusion, or contractures. The cervical spine examination revealed moderate muscle guarding but only mild mobility deficits, and the patient reported complaints of bilateral arm numbness and pain, but no objective motor or reflex changes were reported.

Determination Letters from PRIUM dated 10/03/2014, and 11/04/2014 denied the request for cervical ESIs at bilateral C7 level under fluroscopy with possible monitored anesthesia because there is no indication in any of the recent physical examinations of any objective physical examination findings of radiculopathy, there is no nerve conduction study or MRI available for review, there was no documentation of regular physical therapy,and there is no documentation of prior procedure notes for cervical ESIs.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This claimant is a female with a history of work-related injury to her neck sustained on 12/16/1997. There is a request for cervical epidural steroid injection at bilateral C7 level under fluroscopy with possible monitored anesthesia (64479, 77003, 01992).

An injection consultation dated 09/24/2014 notes neurological examination showed DTRs to be 2/4 and symmetric in the biceps, triceps, and brachioradialis tendon. Motor power was 5/5 and symmetric between myotomes C5 and T1, though there was give-way weakness due to pain. Sensation was reported to be well- preserved in the upper extremities. On 10/14/2014, she was examined who reported the neurologic exam to show good coordination with no objective deficits of strength, sensation, or reflexes. Extremity joints showed good stability and ROM, without deformity, malalignment, effusion, or contractures. The cervical spine examination revealed moderate muscle guarding but only mild mobility deficits, and the patient reported complaints of bilateral arm numbness and pain, but no objective motor or reflex changes were reported. ODG notes that in order to perform epidural steroid injections radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There is an absence in documentation noting that this claimant

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has radiculophaty on exam, with her physical exam showing no evidence of radiculopathy. Therefore, the medical necessity of this request is not established and the request is non-certified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

☐ **INTERQUAL CRITERIA**

☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

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ODG – Neck and Upper Back (Acute & Chronic)
Epidural steroid injection (ESI):
Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. In a recent Cochrane review, there was one study that reported improvement in pain and function at four weeks and also one year in individuals with chronic neck pain with radiation. (Peloso-Cochrane, 2006) (Peloso, 2005) Other reviews have reported moderate short-term and long-term evidence of success in managing cervical radiculopathy with interlaminar ESIs. (Stav, 1993) (Castagnera, 1994) Some have also reported moderate evidence of management of cervical nerve root pain using a transforaminal approach. (Bush, 1996) (Cyteval, 2004) A recent retrospective review of interlaminar cervical ESIs found that approximately two-thirds of patients with symptomatic cervical radiculopathy from disc herniation were able to avoid surgery for up to 1 year with treatment. Success rate was improved with earlier injection (< 100 days from diagnosis). (Lin, 2006) There have been recent case reports of cerebellar infarct and brainstem herniation as well as spinal cord infarction after cervical transforaminal injection. (Beckman, 2006) (Ludwig, 2005) Quadriparesis with a cervical ESI at C6-7 has also been noted (Bose, 2005) and the American Society of Anesthesiologists Closed Claims Project database revealed 9 deaths or cases of brain injury after cervical ESI (1970-1999). (Fitzgibbon, 2004) These reports were in contrast to a retrospective review of 1,036 injections that showed that there were no catastrophic complications with the procedure. (Ma, 2005) The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) There is evidence for short-term symptomatic improvement of radicular symptoms with epidural or selective root injections with corticosteroids, but these treatments did not appear to decrease the rate of open surgery. (Haldeman, 2008) (Benyamin, 2009) Epidural steroid injections should be reserved for those who may otherwise undergo open surgery for nerve root compromise. (Bigos, 1999) Intramuscular injection of lidocaine for chronic mechanical neck disorders (MND) and intravenous injection of methylprednisolone for acute whiplash were effective treatments. There was limited evidence of effectiveness of epidural injection of methyl prednisolone and lidocaine for chronic MND with radicular findings. (Peloso-Cochrane, 2006) The FDA is warning that injection of corticosteroids into the epidural space of the spine may result in rare but serious adverse events, including loss of vision, stroke, paralysis, and death. (FDA, 2014) See the Low Back Chapter for more information and references.
Criteria for the use of Epidural steroid injections, therapeutic:

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Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) for guidance
(4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
(8) Repeat injections should be based on continued objective documented pain and function response.
(9) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day.
Criteria for the use of Epidural steroid injections, diagnostic:
To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.